

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

5998-60-024485

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5998

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1485 Arlington		d. STREET ADDRESS (If outside, give location) 1485 Arlington	

3. NAME OF DECEASED (Type or print) First Henry Middle C. Last Faust, Sr.	4. DATE OF DEATH Month June Day 10 Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/6/94	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months 8 Days 4 Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	11. BIRTHPLACE (City and state or country) St. Louis	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John G. Faust	13b. MOTHER'S MAIDEN NAME Rose B. Heil	14. NAME OF HUSBAND OR WIFE Ida M.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 494-24-9198	17. INFORMANT Ida M. Faust	Address 1485 Arlington
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis (liver metastases)</u> DUE TO (b) <u>Carcinoma of colon</u> DUE TO (c) <u>153.8</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u> <u>2 1/2 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>1956</u> to <u>1960</u> and last saw her <u>6-7-60</u> Death occurred at <u>6-10-60</u> <u>7:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George A. Mahe M.D.</u>	22b. ADDRESS <u>950 Francis Pl.</u>	22c. DATE SIGNED <u>6-11-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/14/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Chas. F. Stuart</u>	ADDRESS <u>1225 Union</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 13 1960</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith M.D.</u>
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Robert M. Murra

Licensed Embalmer No. 374

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.